Authorization to Discuss Protected Health Information

Patient Name (please print clearly): ______________________________ **Date of Birth:** ____________

Phone Number: _______________________________ **Current Age:** _____________

☐ **I DO NOT authorize Pediatric Associates of the Northwest to discuss my health information.**

(If checked, please skip to signature at the bottom)

I authorize Pediatric Associates of the Northwest to discuss the following information.

INITIAL your choice(s). Only the information initialed will be discussed.

_____ **General medical information** **(age ≥ 15)**

_____ **Birth control** **(any age)**

_____ **Sexual health including sexually transmitted diseases/ HIV/AIDS** **(age ≥ 14)**

_____ **Drug and/or alcohol use** **(age ≥ 14)**

_____ **Mental health** **(age ≥ 14)**

_____ **Other:** ____________________________

☐ **I DO authorize Pediatric Associates of the Northwest to discuss my health information with:**

1. **Name:** __________________________ **Phone:** __________________________

   Relationship to patient: __________________________

2. **Name:** __________________________ **Phone:** __________________________

   Relationship to patient: __________________________

This authorization is valid for one year and may be revoked by the patient (verbally or in writing) at any time prior to one year. To revoke this authorization, please send a written statement to Medical Records at Pediatric Associates of the NW, 2701 NW Vaughn St, Suite 360, Portland, OR 97210 and state you are revoking the authorization. Any use or disclosure already made with your permission cannot be undone.

____ Signature of Patient

_____________________________________ Date

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